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I. SUMMARY AND BACKGROUND

A. Purpose and Summary

The bill, H.R. 4946, as amended (the "Improving Access to Long-Term Care Act of 2002") provides tax relief to assist individuals in meeting the long-term care needs of themselves, their spouse, and their dependents.

The bill provides an above-the-line deduction for individuals with certain income levels for the purchase of long-term care insurance. In addition, the bill provides a phased-in additional personal exemption for taxpayers who care for dependents with long-term care needs in their home.

The bill also expands human clinical trials that qualify for the orphan drug credit, adds hepatitis A vaccine to the list of taxable vaccines, makes a conforming change to the coal industry health provisions to reflect the Committee's actions relating to prescription drug benefits under Medicare, and allows individuals enrolled in Medicare+Choice MSA plans to contribute to Archer MSAs.

B. Background and Need for Legislation

The provisions approved by the Committee reflect the need for tax relief to assist individuals in meeting their long-term care needs. The provisions also address other health care matters.

C. Legislative History

Committee Action

The Committee on Ways and Means marked up the provisions of the bill on June 19, 2002, and approved the provisions, as amended, on June 19,2002, by a roll call vote of 29 yeas to 6 nays (with a quorum being present).

II. EXPLANATION OF THE BILL

A. Above-the-Line Deduction for Long-Term Care Insurance Premiums (sec. 2 of the bill and new sec. 223 of the Code)

Present Law

Under present law, the Federal income tax treatment of qualified long-term care insurance expenses is similar to the treatment of health insurance expenses.[1] As is the case with health insurance expenses, the Federal income tax treatment of qualified long-term care insurance expenses depends on the individual's circumstances.

Individuals who purchase their own qualified long-term care insurance may claim an itemized deduction for the premiums, but only to the extent that eligible qualified long-term care insurance premiums, together with the individual's medical expenses exceed 7.5 percent of adjusted gross income.[2] The amount of qualified long-term care insurance premiums that may be taken into account in determining the amount allowed as an itemized deduction is limited as follows (for 2002) based on the case of the covered individual: $240 in the case of an individual 40 years old or less; $450 in the case of an individual who is more than 40 but not more than 50; $900 in the case of an individual who is more than 50 but not more than 60; $2,390 in the case of an individual who is more than 60 but not more than 70; and $2,990 in the case of an individual who is more than 70. These dollar limits are indexed for inflation.

Self-employed individuals may deduct a portion of qualified long-term care insurance premiums for the individual and his or her spouse and dependents. The deductible percentage of such premiums is 70 percent in 2002 and 100 percent in 2003 and thereafter.[3] The deduction applies to qualified long-term care insurance premiums, subject to the same dollar limits that apply for purposes of the itemized deduction, described above.

Employees can exclude from income 100 percent of qualified long-term care insurance paid for by the employee's employer. There is no dollar limit on this exclusion.[4] Payments made under a qualified long-term care insurance contract are excludable from gross income, subject to a dollar limitation in the case of contracts that provide for payment on a per diem or similar basis.

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[1] The main difference between the tax treatment of qualified long-term care insurance and medical insurance is that long-term care insurance cannot be offered under a cafeteria plan.

[2] Sec. 213(d).

[3] The deduction for long-term care insurance expenses of self-employed individuals is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse.

[4] Unlike health insurance, long-term care insurance cannot be provided under a cafeteria plan.

In order for a long-term care insurance contract to be a qualified long-term care insurance contract: (1) the contract must be guaranteed renewable; (2) the contract generally cannot provide for a cash surrender value or other money that can be paid, assigned, or pledged as a loan or borrowed; (3) all refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits; and (4) the contract must meet certain consumer protection standards.[5] Contracts that provide for per diem or similar payments are subject to additional requirements.

The consumer protection provisions applicable to qualified long-term care insurance contracts require that (1) such contracts meet certain provisions under the model long-term care insurance act and regulations promulgated by the National Association of Insurance Commissioners, (2) the issuer of the contract discloses that the contract is intended to be a qualified policy, and (3) the issuer offer the policyholder a nonforfeiture provision meeting certain requirements.

Reasons for Change

Present law provides favorable tax treatment for the purchase of qualified long-term care insurance. The present-law provisions were enacted to provide incentives for individuals to take financial responsibility for the long-term care needs of themselves and their dependents. The Committee believes that further incentives and tax relief are appropriate to encourage individuals to purchase qualified long-term care insurance.

Explanation of Provision

The provision provides an above-the-line deduction for a percentage of qualified long-term care insurance premiums up to the present-law dollar limitations that apply under the itemized deduction.[6] The deduction is not available to an individual for any month in which the individual is covered under a long-term care insurance contract 50 percent or more of the cost of which is paid or incurred by the individual's employer (or the employer of the individual's spouse). In determining whether the 50-percent threshold is met, all plans of related employers providing long-term care insurance in which the individual participates are treated as a single plan.

The otherwise allowable deduction is phased out for taxpayers with modified adjusted gross income between $20,000 and $40,000 ($40,000 and $80,000 in the case of married taxpayers filing a joint return).[7] The $20,000 and $40,000 starting points for the phase-out range are indexed for inflation, rounded to the nearest $1,000.

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[5] Sec. 7702B.

[6] The deduction only applies to premiums on qualified long-term care insurance contracts; it does not apply to long-term care expenses.

[7] Modified adjusted gross income means adjusted gross income determined without regard to the deduction provided by the provision and the exclusion for certain foreign earned income (sec. 911), income from Guam, American Samoa, or the Northern Mariana Islands (sec.

The deductible percentage of qualified long-term care insurance premiums is 25 percent in 2003, 2004, and 2005, 30 percent in 2006 and 2007, 35 percent in 2008 and 2009, 40 percent in 2010 and 2011, and 50 percent in 2012 and thereafter.

No amount taken into account in computing the deduction may be taken into account in determining the deduction for health insurance expenses of self-employed individuals or the itemized deduction for medical expenses. Married taxpayers are required to file a joint return in order to claim the deduction.[8] The Secretary is authorized to prescribe such regulations as may be appropriate to carry out the provision, including appropriate reporting requirements for employers.

Effective Date

The provision is effective for taxable years beginning after December 31, 2002.

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931), and income from Puerto Rico (sec. 933). Modified adjusted gross income is calculated after the determination of the amount of Social Security benefits includible in gross income (sec. 86), the exclusion for certain interest on education savings bonds (sec. 135), the exclusion for adoption assistance (sec. 137), the deduction for contributions to individual retirement arrangements (sec. 219), the deduction for student loan interest (sec. 221), the deduction for certain education expenses (sec. 222), and the deduction for passive activity losses (sec. 469).

[8] The rules of sec. 7703 would apply in determining married status for this purpose.

B. Provide an Additional Personal Exemption to Home Caregivers of Family Members (sec. 3 of the bill and sec. 151 of the Code)

Present Law

In determining taxable income, taxpayers are entitled to a personal exemption deduction for the taxpayer, his or her spouse, and each dependent. To qualify as a dependent under present law, an individual must: (1) be (a) a specified relative or (b) have as his or her principal place of abode for the taxable year the home of the taxpayer and be a member of the taxpayer's household;[9] (2) be a citizen or resident of the U.S. or resident of Canada or Mexico; (3) not be required to file a joint tax return with his or her spouse; (4) have gross income below the personal exemption amount if not the taxpayer's child; and (5) receive over half of his or her support from the taxpayer.[10]

The personal exemption amount for 2002 is $3,000. Personal exemptions are phased-out by two percentage points for each $2,500 ($1,250 if married filed separately) or fraction thereof by which adjusted gross income exceeds certain thresholds based on filing status. For 2002, the thresholds are $137,300 for single filers, $206,000 for joint filers, $171,650 for heads of household, and $103,000 for married taxpayers filing separate returns.[11] The exemption amount and the dollar thresholds for the phase-out are indexed for inflation.

Present law provides favorable tax treatment for the purchase of qualified long-term care insurance and for individuals with qualified long-term care expenses.

Reasons for Change

Present law provides favorable tax treatment for long-term care insurance and expenditures on long-term care services, but does not provide similar tax relief for in-home care, i.e., for individuals who care for family members or other dependents in their home. The

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[9] For purposes of this rule, the taxpayer must maintain the household in which the taxpayer and the individual reside. The taxpayer is considered to maintain the household if over one-half of the support of the household is provided by the taxpayer (or, if married, the taxpayer and his or her spouse).

[10] If no one person contributes over half the support of an individual, the taxpayer is treated as meeting the support requirement if: (a) over half the support is received from persons each of whom, but for the fact that he or she did not provide over half such support, could claim the individual as a dependent; (b) the taxpayer contributes over 10 percent of such support; and (c) the other caregivers who provide over 10 percent of the support file written declarations stating that they will not claim the individual as a dependent.

[11] For taxable years beginning in 2006 and 2007, the otherwise applicable personal exemption phase-out is reduced by one-third and for taxable years beginning in 2008 and 2009, the otherwise applicable phase-out is reduced by two-thirds. The personal exemption phaseout is repealed for taxable years beginning after December 31, 2009, and reinstated for taxable years beginning after December 31, 2010.

Committee understands that in-home care may be preferable in some cases, and that individuals who care for family members or other dependents with special needs often incur additional household expenses. The Committee believes it appropriate to provide additional tax relief in such cases.

Explanation of Provision

The provision allows a phased-in additional personal exemption for each qualified family member with long-term care needs. The exemption amount is limited to $500 for 2003 and 2004, $1,000 for 2005 and 2006, $1,500 for 2007 and 2008, and $2,000 for 2009 and 2010, $2,500 for 2011, and is equal to the regularly applicable exemption amount for 2012 and thereafter.

A qualified family member means an individual with long-term care needs who (1) is the spouse of the taxpayer or a dependent of the taxpayer or the taxpayer's spouse with respect to whom the taxpayer is allowed to claim a personal exemption, and (2) satisfies a residency requirement. In the case of an individual who is a dependent by reason of living in the taxpayer's household for the entire taxable year, the residency requirement is the same as that under the dependency exemption. In the case of other dependents, the residency requirement is satisfied if, for more than one half of the taxable year, the individual has as his or her principal place of abode the home of the taxpayer and is a member of the taxpayer's household. As under present law, a taxpayer would be treated as maintaining a household for a period only if the taxpayer (or, if married, the taxpayer and his or her spouse) furnishes more than one-half the cost of maintaining the household for the entire year.

An individual is considered to have long-term care needs if he or she has been certified by a licensed physician as being unable, for a period of at least 180 consecutive days[12], to perform at least two activities of daily living ("ADLs")[13] without substantial assistance from another individual due to a loss of functional capacity. Substantial assistance includes both hands-on assistance (that is, the physical assistance of another person without which the individual would be unable to perform the ADL) and stand-by assistance (that is, the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual when performing the ADL).

As an alternative to the two-ADL test described above, an individual is considered to have long-term care needs if he or she has been certified by a licensed physician as, for at least 180 consecutive days: (1) requiring substantial supervision to be protected from threats to health and safety due to severe cognitive impairment and (2) being unable to perform at least one ADL or to engage in age appropriate activities as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.

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[12] Some portion of the period must be within the taxable year.

[13] As under the present-law rules relating to long-term care, ADLs are defined as eating, toileting, transferring, bathing, dressing, and continence.

In all cases, the required certification must be made during the 39-1/2 month period ending on the due date (without extensions) for filing the return for the taxable year (or such other period as the Secretary of the Treasury may prescribe).

Married couples may not claim the additional personal exemption unless they file a joint return. An individual who is legally separated from his or her spouse is not considered married. In addition, married individuals who live apart during the last six months of the year are not considered married if certain requirements are satisfied.

The taxpayer is required to provide a correct physician identification number (e.g., the Unique Physician Identification Number that is currently required for Medicare billing) for the certifying physician. Failure to provide correct physician identification numbers is subject to the mathematical error rule. Under that rule, the IRS may summarily assess additional tax due without sending the individual a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court.

Effective Date

The provision is effective for taxable years beginning after December 31, 2002.

C. Expand Human Clinical Trials Expenses Qualifying for the Orphan Drug Tax Credit (sec. 4 of the bill and sec. 45C of the Code)

Present Law

Taxpayers may claim a 50-percent credit for expenses related to human clinical testing of drugs for the treatment of certain rare diseases and conditions, generally those that afflict less than 200,000 persons in the United States. Qualifying expenses are those paid or incurred by the taxpayer after the date on which the drug is designated as a potential treatment for a rare disease or disorder by the Food and Drug Administration ("FDA") in accordance with section 526 of the Federal Food, Drug, and Cosmetic Act.

Reasons for Change

The Committee understands that approval for human clinical testing and designation as a potential treatment for a rare disease or disorder require separate reviews within the FDA. As a result, in some cases, a taxpayer may be permitted to begin human clinical testing prior to a drug being designated as a potential treatment for a rare disease or disorder. If the taxpayer delays human clinical testing in order to obtain the benefits of the orphan drug tax credit, which currently may be claimed only for expenses incurred after the drug is designated as a potential treatment for a rare disease or disorder, valuable time will have been lost and Congress's original intent in enacting the orphan drug tax credit will have been partially thwarted. Because taxpayers generally seek designation of a potential drug as a treatment for a rare disease or disorder at the time they seek approval to clinically test such drugs, the Committee believes it is appropriate to make such expenses related to human clinical testing that the taxpayer incurs prior to FDA designation eligible for the orphan drug tax credit to help speed cures to such insidious diseases.

Explanation of Provision

The bill expands qualifying expenses to include those expenses related to human clinical testing incurred after the date on which the taxpayer files an application with the FDA for designation of the drug under section 526 of the Federal Food, Drug, and Cosmetic Act as a potential treatment for a rare disease or disorder. As under present law, the credit may only be claimed for such expenses related to drugs designated as a potential treatment for a rare disease or disorder by the FDA in accordance with section 526 of such Act.

Effective Date

The provision is effective for expenditures paid or incurred after the date of enactment.

D. Add Vaccines Against Hepatitis A to the List of Taxable Vaccines (sec. 5 of the bill and sec. 4131 of the Code)

Present Law

A manufacturer's excise tax is imposed at the rate of 75 cents per dose (sec. 4131) on the following vaccines routinely recommended for administration to children: diphtheria, pertussis, tetanus, measles, mumps, rubella, polio, HIB (haemophilus influenza type B), hepatitis B, varicella (chicken pox), rotavirus gastroenteritis, and streptococcus pneumoniae. The tax applied to any vaccine that is a combination of vaccine components equals 75 cents times the number of components in the combined vaccine.

Amounts equal to net revenues from this excise tax are deposited in the Vaccine Injury Compensation Trust Fund to finance compensation awards under the Federal Vaccine Injury Compensation Program for individuals who suffer certain injuries following administration of the taxable vaccines. This program provides a substitute Federal, "no fault" insurance system for the State-law tort and private liability insurance systems otherwise applicable to vaccine manufacturers. All persons immunized after September 30, 1988, with covered vaccines must pursue compensation under this Federal program before bringing civil tort actions under State law.

Reasons for Change

The Committee is aware that the Centers for Disease Control and Prevention have recommended that children in 17 highly endemic States be inoculated with a hepatitis A vaccine. The population of children in the affected States exceeds 20 million. Several of the affected States mandate childhood vaccination against hepatitis A. The Committee is aware that the Advisory Commission on Childhood Vaccines has recommended that the vaccine excise tax be extended to cover vaccines against hepatitis A. For these reasons, the Committee believes it is appropriate to include vaccines against hepatitis A as part of the Vaccine Injury Compensation Program. Making the hepatitis A vaccine taxable is a first step.[14] In the unfortunate event of an injury related to this vaccine, families of injured children would be eligible for the no-fault arbitration system established under the Vaccine Injury Compensation Program rather than going to Federal Court to seek compensatory redress.

Explanation of Provision

The committee bill adds any vaccine against hepatitis A to the list of taxable vaccines.

Effective Date

The provision is effective for vaccines sold beginning on the first day of the first month beginning more than four weeks after the date of enactment.

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[14] The Committee recognizes that, to become covered under the Vaccine Injury Compensation Program, the Secretary of Health and Human Services also must list the hepatitis A vaccine on the Vaccine Injury Table.

E. Adjustment of Employer Contributions to Combined Benefit Fund to Reflect Medicare Prescription Drug Benefit (sec. 6 of the bill and sec. 9704 of the Code)

Present Law

Under present law, certain persons are required to pay premiums to the United Mine Workers of America Combined Benefit Fund (the "Combined Fund") established to provide health benefits for certain coal industry workers.

Reasons for Change

The Committee believes it appropriate to modify the premium requirements under the Combined Fund to reflect the Medicare prescription drug benefits adopted by the Committee in H.R. 4954, the "Medicare Modernization and Prescription Drug Act of 2002" on June 18, 2002.

Explanation of Provision

The provision provides that the trustees of the Combined Fund are to decrease otherwise provided premiums for each year in which a subsidy payment is provided in the Medicare Modernization and Prescription Drug Act of 2002 in order to place the Fund in the same financial position as if the subsidy payment had not been received.

Effective Date

The provision applies to plan years beginning after the date of enactment of the Medicare Modernization and Prescription Drug Act of 2002.

F. Modifications to Medicare+Choice MSAs (sec. 7 of the bill and sec. 220 of the Code)

Present Law

In general

Present law provides for favorable tax treatment for Archer medical savings accounts ("MSAs") and Medicare+Choice MSAs.[15]

Archer MSAs

Within limits, contributions to an Archer MSA are deductible in determining adjusted gross income if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. In general, eligible individuals are self-employed individuals covered by a high deductible health plan[16] and employees covered under a high deductible health plan of a small employer.[17] The maximum contribution that can be made to an Archer MSA for a year is 65 percent of the deductible under the high deductible plan in the case of individual coverage, and 75 percent of the deductible in the case of family coverage. An eligible individual or the employer of an eligible individual may contribute to an Archer MSA, but not both.

Earnings on amounts in an Archer MSA are not currently includible in income. Distributions from an Archer MSA for medical expenses of the MSA account holder and his or her spouse or dependents are not includible in income. For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include any insurance premiums other than premiums for long-term care insurance, continuation coverage ("COBRA coverage"), or premiums for coverage while an individual is receiving unemployment compensation. Distributions not used for medical expenses are subject to an additional 15-percent tax unless the distribution is made after age 65, death, or disability.

Individuals who are covered by Medicare are not eligible for an Archer MSA, but may be eligible for a Medicare+Choice MSA as described below.

The number of Archer MSAs that may be established is limited. In general, no new Archer MSAs can be established after 2003.

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[15] In general, an MSA is a trust or custodial account created exclusively for the benefit of the account holder and that meets certain other requirements. The trustee of an MSA can be a bank, insurance company, or other person as specified by the Secretary of the Treasury.

[16] A high deductible health plan is a plan that meets certain requirements with respect to the amount of the annual deductible and out-of-pocket limitations.

[17] In order to be eligible for an MSA, the individual generally cannot be covered under a health plan other than the high deductible health plan.

Medicare+Choice MSAs

Under present law, the Medicare program includes a variety of health plan options called Medicare+Choice. One of the Medicare+Choice options is a test program called the Medicare+Choice medical savings account ("MSA") plan. The Medicare+Choice MSA plan consists of two parts, a Medicare+Choice health policy and a Medicare+Choice MSA.

Individuals who elect the Medicare+Choice MSA plan select a policy from a commercial insurer. The policy must be designed to work as part of the Medicare+Choice MSA plan and must be approved by Medicare. The premium for the policy is paid for by Medicare.

In addition, individuals who elect the Medicare+Choice MSA plan establish a Medicare+Choice MSA with a bank or other institution that is registered with Medicare to set up Medicare+Choice MSAs. The Secretary of Health and Human Services makes a specified contribution directly into a Medicare+Choice MSA designated by such individual based on the policy the individual is covered by and certain other factors. Only contributions by the Secretary of Health and Human Services can be made to a Medicare+Choice MSA. Such contributions are not included in the taxable income of Medicare+Choice MSA holder.

Income earned on amounts held in a Medicare+Choice MSA is not currently includible in taxable income. Withdrawals from a Medicare+Choice MSA are excludable from taxable income if used for the qualified medical expenses of the account holder. Withdrawals that are not used for the qualified medical expenses of the account holder are includible in income and may be subject to an additional tax (described below).

Distributions from a Medicare+Choice MSA that are used to pay the qualified medical expenses of the account holder are excludable from taxable income regardless of whether the account holder is enrolled in the Medicare+Choice MSA plan at the time of the distribution. Qualified medical expenses of the account holder are generally defined as under the rules relating to the itemized deductions for medical expenses. However, for this purpose, qualified medical expenses do not include any insurance premiums other than premiums for long-term care insurance, COBRA coverage, or premium for coverage while an individual is receiving unemployment compensation. In addition, expenses of the taxpayer's spouse and dependents are not qualified medical expenses.

Distributions for purposes other than qualified medical expenses are includible in taxable income. An additional tax of 50 percent applies to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of Medicare+Choice MSA as of December 31 of the preceding taxable year exceeds 60 percent of the deductible of the plan under which the individual is covered. The additional tax does not apply to distributions on account of the disability or death of the account holder.

Reasons for Change

The Committee believes it appropriate to increase the attractiveness of the Medicare+Choice MSA program by allowing individuals in such program to be eligible for Archer MSAs.

Explanation of Provision

The provision treats policies selected as part of the Medicare+Choice MSA plan as high deductible plans for purposes of Archer MSAs. Thus, individuals who have a Medicare+Choice MSA plan also are eligible individuals for Archer MSA purposes (such individuals are referred to as "Medicare-eligible individuals"). The maximum deductible contribution that may be made to an Archer MSA with respect to a Medicare-eligible individual is 100 percent of the deductible under the Medicare+Choice MSA policy.

The proposal also allows employers or former employers of Medicare-eligible individuals to make contributions to an Archer MSA on behalf of such individuals. Total contributions can not exceed the deductible amount.

The cap on Archer MSAs does not apply to MSAs established by persons in Medicare+Choice. As under present law, the Archer MSA program, including the program as applied to Medicare-eligible individuals, expires at the end of 2003.

Effective Date

The provision is effective for taxable years beginning after December 31, 2002.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 4946.

MOTION TO REPORT THE BILL

The bill, H.R. 4946, as amended, was ordered favorably reported by a roll call vote of 29 yeas to 6 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas.....	Ö			Mr. Rangel.....		Ö	
Mr. Crane.....				Mr. Stark.....		Ö	
Mr. Shaw.....	Ö			Mr. Matsui.....		Ö	
Mrs. Johnson.....	Ö			Mr. Coyne.....			
Mr. Houghton.....	Ö			Mr. Levin.....	Ö		
Mr. Herger.....	Ö			Mr. Cardin.....	Ö		
Mr. McCrery.....	Ö			Mr. McDermott.....		Ö	
Mr. Camp.....	Ö			Mr. Kleczka.....	Ö		
Mr. Ramstad.....	Ö			Mr. Lewis (GA).....		Ö	
Mr. Nussle.....	Ö			Mr. Neal.....			
Mr. Johnson.....	Ö			Mr. McNulty.....			
Ms. Dunn.....	Ö			Mr. Jefferson.....			
Mr. Collins.....	Ö			Mr. Tanner.....	Ö		
Mr. Portman.....	Ö			Mr. Becerra.....		Ö	
Mr. English.....	Ö			Mrs. Thurman.....	Ö		
Mr. Watkins.....	Ö			Mr. Doggett.....			
Mr. Hayworth.....	Ö			Mr. Pomeroy.....	Ö		
Mr. Weller.....	Ö						
Mr. Hulshof.....	Ö						
Mr. McInnis.....	Ö						
Mr. Lewis (KY).....	Ö						
Mr. Foley.....	Ö						
Mr. Brady.....	Ö						
Mr. Ryan.....	Ö						

VOTES ON AMENDMENTS

A roll call vote was conducted on the following amendment to the Chairman's amendment in the nature of a substitute.

An amendment by Mr. McCrery, which would provide retirees with additional flexibility in obtaining health care for retirees and their families by allowing employers or former employers to make contributions to an Archer MSA on behalf of a Medicare eligible individual, was agreed to by a roll call vote of 23 yeas to 12 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas.....	Ö			Mr. Rangel.....		Ö	
Mr. Crane.....				Mr. Stark.....		Ö	
Mr. Shaw.....	Ö			Mr. Matsui.....		Ö	
Mrs. Johnson.....	Ö			Mr. Coyne.....			
Mr. Houghton.....	Ö			Mr. Levin.....		Ö	
Mr. Herger.....	Ö			Mr. Cardin.....		Ö	
Mr. McCrery.....	Ö			Mr. McDermott.....		Ö	
Mr. Camp.....	Ö			Mr. Kleczka.....		Ö	
Mr. Ramstad.....	Ö			Mr. Lewis (GA).....		Ö	
Mr. Nussle.....	Ö			Mr. Neal.....			
Mr. Johnson.....	Ö			Mr. McNulty.....			
Ms. Dunn.....	Ö			Mr. Jefferson.....			
Mr. Collins.....	Ö			Mr. Tanner.....		Ö	
Mr. Portman.....	Ö			Mr. Becerra.....		Ö	
Mr. English.....	Ö			Mrs. Thurman.....		Ö	
Mr. Watkins.....	Ö			Mr. Doggett.....			
Mr. Hayworth.....	Ö			Mr. Pomeroy.....		Ö	
Mr. Weller.....	Ö						
Mr. Hulshof.....	Ö						
Mr. McInnis.....	Ö						
Mr. Lewis (KY).....	Ö						
Mr. Foley.....	Ö						
Mr. Brady.....	Ö						
Mr. Ryan.....	Ö						

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d)(2) of the rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 4946 as reported.

The bill is estimated to have the following effects on budget receipts for fiscal years 2003-2007:

ESTIMATED REVENUE EFFECTS OF H.R. 4946,
THE "IMPROVING ACCESS TO LONG-TERM CARE ACT OF 2002,"
AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

Fiscal Years 2003 - 2007

[Millions of Dollars]

Provision	Effective	2003	2004	2005	2006	2007	2003-07
1. Provide an above-the-line deduction for long-term care insurance expenses for which the taxpayer pays at least 50% of the cost of coverage (25% in 2003 through 2005, 30% in 2006 and 2007, 35% in 2008 and 2009, 40% in 2010 and 2011, and 50% in 2012 and thereafter with AGI phaseout of $40,000 to $80,000 for joint filers and $20,000 to $40,000 for other filers) [1]	tyba 12/31/02	-19	-130	-140	-160	-199	-648
2. Provide an additional personal exemption to home caregivers of dependents with long-term care needs ($500 in 2003 and 2004, $1,000 in 2005 and 2006, $1,500 in 2007 and 2008, $2,000 in 2009 and 2010, $2,500 in 2011, and a full personal exemption, as indexed, in 2012 and thereafter)	tyba 12/31/02	-79	-108	-176	-184	-239	-787
3. Expand human clinical trials expenses qualifying for the orphan drug tax credit	epoia DOE	-13	-20	-22	-24	-26	-105
4. Add vaccines against Hepatitis A to the list of taxable vaccines	[2]	5	8	9	9	9	39
5. Adjustment of employer contributions to Combined Benefit Fund to reflect Medicare prescription drug subsidy payments [3]	[4]	- - - - - - - - - - - - - - - - - - *No Revenue Effect* - - - - - - - - - - - - - - - - - -					
6. Allow individual and employer contributions to Archer MSAs for individuals enrolled in Medicare+Choice MSA plans	tyba 12/31/02	- - - - - - - - - - - - - - - *Negligible Revenue Effect* - - - - - - - - - - - - - - -					
NET TOTAL		**-106**	**-250**	**-329**	**-359**	**-455**	**-1,501**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column:
DOE = date of enactment
epoia = expenses paid or incurred after
tyba = taxable years beginning after

[1] Estimate assumes that the AGI phaseouts for the deduction would be indexed to changes in the Consumer Price Index, rounded to the nearest $1,000.
[2] Effective for vaccines sold beginning the first day of the first month beginning four weeks after the date of enactment.
[3] Estimate provided by the Congressional Budget Office. This provision would have no revenue effect because there is no Medicare prescription drug program under present law. The Congressional Budget Office estimates that, if the Medicare prescription drug program in H.R. 4954 were enacted concurrently with H.R. 4946, this provision would result in a total revenue loss of $92 million over fiscal years 2005 through 2012.
[4] Effective for plan years beginning after the date of enactment of the Medicare Modernization and Prescription Drug Act of 2002.

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority (as detailed in the statement by the Congressional Budget Office ("CBO"); see Part IV.C., below). The Committee further states that the revenue reducing income tax provisions involve increased tax expenditures. (See amounts in table in Part IV.A., above.)

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

[Insert CBO letter (to be supplied)]

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Dan L. Crippen, Director

June 25, 2002

Honorable William "Bill" M. Thomas
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4946, the Improving Access to Long-Term Care Act of 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Andrew Shaw (for federal revenues), who can be reached at 226-2678, and Alexis Ahlstrom (for federal spending), who can be reached at 226-9010.

Sincerely,

Dan L. Crippen

Enclosure

cc: Honorable Charles B. Rangel
Ranking Democrat

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 25, 2002

H.R. 4946
Improving Access to Long-Term Care Act of 2002

As ordered reported by the House Committee on Ways and Means on June 19, 2002

SUMMARY

H.R. 4946 would provide an above-the-line deduction for a percentage of premiums for eligible long-term care insurance contracts. The deduction would be available for eligible long-term care insurance that covers the taxpayer, the taxpayer's spouse or the taxpayer's dependents and for which the taxpayer pays at least 50 percent of the cost of coverage. The deduction would phase out for single taxpayers with adjusted gross income (AGI) between $20,000 and $40,000 a year and for married taxpayers filing jointly with AGI between $40,000 and $80,000.

H.R. 4946 would also allow an additional personal exemption for taxpayers who provide home care to dependents with long-term care needs. This additional exemption would be phased in starting at $500 in 2003 and 2004, increasing in $500 increments every other year thereafter until it reaches $2,500 in 2011. Starting in 2012, a full personal exemption would apply.

In addition, the bill would add vaccines against Hepatitis A to the list of taxable vaccines, expand human clinical trial expenses qualifying for the orphan drug tax credit, and adjust employer contributions to the Combined Benefit Fund to reflect Medicare payments for prescription drug subsidies.

The Joint Committee on Taxation (JCT) and CBO estimate that enacting H.R. 4946 would reduce revenues by $106 million in 2003, $1.5 billion over the 2003-2007 period, and $5.5 billion over the 2003-2012 period. CBO estimates that the bill would increase direct spending by $5 million in 2003, $34 million over the 2003-2007 period, and $70 million over the 2003-2012 period. Because the bill would affect revenues and direct spending, pay-as-you-go procedures would apply. JCT and CBO have determined that the bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA), and would not affect the budgets of state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4946 is shown in the following table.

	By Fiscal Year, in Millions of Dollars					
	2002	2003	2004	2005	2006	2007
CHANGES IN REVENUES						
Estimated Revenues	0	-106	-250	-329	-359	-455
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	5	7	7	7	7
Estimated Outlays	0	5	7	7	7	7

BASIS OF ESTIMATE

Revenues

All revenue estimates for H.R. 4946 were provided by JCT except for the provision adjusting employer contributions to the Combined Benefit Fund to reflect Medicare prescription drug subsidy payments. CBO estimates the revenue effect of that provision, by itself, would be zero because Medicare does not have an outpatient prescription drug benefit under current law. However, H.R. 4946, if enacted concurrently with or after the establishment of a Medicare prescription drug benefit, would decrease revenues in the form of health care premiums paid to the Combined Benefit Fund by certain coal companies.

The Combined Benefit Fund was created in 1992 to provide health benefits to retired coal industry workers. Under current law, the premiums coal companies pay to the fund on behalf of retired workers can be increased in the event that Medicare reduces its benefits to ensure that the same level of benefits is maintained. In contrast, there is no mechanism to decrease premiums if Medicare adds benefits. This provision would require the fund to reduce the premiums that coal companies pay to the fund by the amount the fund would receive from Medicare for the prescription drug benefit. The estimate assumes that the fund would make arrangements with Medicare to enroll all Medicare-eligible fund participants in the drug benefit and that the fund would pay the premiums and cost-sharing associated with participation in that plan.

CBO estimates the cost of implementing this provision in conjunction with the prescription drug benefit specified in H.R. 4954 (as ordered reported by the Committee on Ways and Means on June 19) would be $35 million over the 2003-2007 period and $92 million over the 2003-2012 period. (Those estimates are not included in the above table, which provides estimated changes in revenues relative to current law only.)

Direct Spending

The Hepatitis A vaccine tax provision would require vaccine buyers to pay an excise tax on each dose purchased. Medicaid is a major purchaser of vaccines through the Vaccines for Children program, administered through the Centers for Disease Control and Prevention (CDC). CBO assumes that Medicaid purchases approximately half of the Hepatitis A vaccines sold annually. Based on estimates provided by JCT, CBO expects that implementing H.R. 4946 would cost the Medicaid program about $3 million in 2003 and $48 million over the 2003-2012 period.

Receipts from the tax would go to the Vaccine Injury Compensation Fund (VICF), which is administered by the Health Resources and Services Administration (HRSA). The fund uses tax revenues to pay compensation to claimants injured by vaccines. Once a vaccine becomes taxable, injuries attributed to its use become compensable through this fund. Based on information provided by HRSA and CDC, we assume there will be few compensable claims related to the Hepatitis A vaccine. CBO estimates the provision would increase outlays from the VICF by $2 million in 2003 and $22 million over the 2003-2012 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in receipts	0	-106	-250	-329	-359	-455	-498	-607	-662	-923	-1,297
Changes in outlays	0	5	7	7	7	7	7	7	7	7	8

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

JCT and CBO have determined that the bill contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

ESTIMATE PREPARED BY:

Federal Revenues: Andrew Shaw (226-2678)
Federal Outlays: Alexis Ahlstrom (226-9010)
Impact on State, Local, and Tribal Governments: Susan Sieg Tompkins (225-3220)
Impact on the Private Sector: Stuart Hagan (226-2666)

ESTIMATE APPROVED BY:

G. Thomas Woodward
Assistant Director for Tax Analysis

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was a result of the Committee's oversight review concerning the tax burden on individual taxpayers and tax-related health issues that the Committee concluded that it is appropriate and timely to enact the revenue provisions included in the bill as reported.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. Constitutional Authority Statement

With respect to clause 3(d)(1) of the rule XIII of the Rules of the House of Representatives (relating to Constitutional Authority), the Committee states that the Committee's action in reporting this bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises. . . "), and from the 16th Amendment to the Constitution.

D. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (P.L. 104-4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, and tribal governments.

E. Applicability of House Rule XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not involve any Federal income tax rate increases within the meaning of the rule.

F. Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the Joint Committee on Taxation (in consultation with the

Internal Revenue Service and the Department of Treasury) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the House Committee on Ways and Means, the Senate Committee on Finance, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

The staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Internal Revenue Code and that have "widespread applicability" to individuals or small businesses.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rule of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

[TO BE SUPPLIED BY LEGISLATIVE COUNSEL'S OFFICE]